



**CHANGE REQUEST FORM**

**NAME**

**SOCIAL SECURITY #**

**DEPARTMENT**

**DIVISION**

**WORK PHONE**

**HOME PHONE**

**The following benefits may be stopped at any time by putting a check mark on the correct line(s).**



FORTIS LONG-TERM DISABILITY PLAN

GROUP LIFE INSURANCE

VOLUNTARY ADDITIONAL AD&D

FRIENDSHIP FUND

LONG TERM CARE – SPOUSE

LONG TERM CARE – EMPLOYEE

EMPLOYEE ASSOCIATION

LEARNING QUEST

If you want to change your Learning Quest contribution, please indicate the new amount.

**\*New deduction amount \$**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE